SPSO decision report

Case: **201903690, Western Isles NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the treatment their child (A) received within A&E at Western Isles Hospital. A was initially seen by a doctor who diagnosed a migraine. A They returned to A&E when their condition deteriorated, and was seen by another doctor, who diagnosed a migraine and possible virus. Following a third visit to A&E, A was diagnosed with a rare condition which is a complication of sinusitis. C complained that one doctor was dismissive and did not take A's symptoms seriously.

We took independent advice from an A&E consultant. We noted that A was diagnosed with a rare condition that A&E staff would not be expected to diagnose. However, we considered that signs were missed that A had a potentially serious underlying condition. While they were satisfied that both initial doctors who saw A initially carried out appropriate examinations, we noted that the blood tests results were not consistent with the diagnosis of migraine or viral infection. We considered that A should not have been discharged before all the blood results were available. We also considered that A should have been reviewed by a senior doctor before discharge on the second attendance, given that it was an unplanned return. We concluded that there was a failure to take appropriate action, which resulted in a delay in investigating and accurately diagnosing A's serious underlying condition. Accordingly, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for discharging A from A&E on two occasions without blood tests results having been identified and acted upon; for not arranging senior review on the second occasion; for the diagnosis being inconsistent with the blood results; and for the consequent delay in further investigation and accurate diagnosis of a serious underlying condition. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Patients returning to A&E with the same complaint should be reviewed by a consultant. The board should consider developing a policy for senior review of unplanned emergency department return patients, if one is not already in place.
- The board should feed this decision back to Doctor 1 and Doctor 2 in a supportive manner and ask that they reflect on A's case, especially with regard to the abnormally elevated neutrophil white blood cell count.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.